Dear Dr. ____________________________  Today’s Date/Time: ___________________

Per your patient’s recent visit, the MFM Specialist has recommended the following:

< 14 weeks Ultrasound + Nuchal Measurement and/or 1st Screen Integrated (Between 11 & 13 weeks gestation)  _____ At 12 weeks

> 14 weeks Ultrasound

Transvaginal (Cervical length)  Start at _____ weeks _____ q 2 weeks until _____ weeks _____ Weekly until ________ weeks

Detailed Ultrasound Complete Ultrasound 19-20 weeks (With Transvaginal as needed)  _____ At 19 weeks  _____ At 20 weeks

Limited Ultrasound (Viability, suboptimal views)  Return in _____ weeks

Fetal Echocardiogram (And/or Repeat Echocardiogram)  _____ At 22 weeks or more, Routine Screening  _____ ASAP/Suspected Fetal Heart Defect

Follow-Up Ultrasound (Growth, EFW, Check fetal status)  Return at _____ weeks  _____ q 3-4 weeks  _____ q 2 weeks

Doppler Middle Cerebral Artery (Risk of anemia/IUGR)  _____ Weekly to start at _____ weeks

Doppler Umbilical Artery  _____ Weekly to start at _____ weeks

Biophysical Profile (With NST if BPP < 8/8)

Fetal Non Stress Test

AMNIOCENTESIS & US GUIDANCE  IN _____ WEEKS OR _____ NEXT APPOINTMENT

TRANSFER TO HIGH RISK CLINIC  IN _____ WEEKS OR _____ NEXT APPOINTMENT

Weekly Labs ____________________________________________________________________

Other Comments/Requests: ____________________________________________________________________

NEW CONSULT RETURN CONSULT NO CONSULT NEEDED

PLEASE REVIEW, MAKE DESIRED CHANGES, THEN SIGN THESE FOLLOW-UP ORDERS ASAP and return to MFM via FAX 231-935-2127.

Thank You.

Physician Signature: ____________________________________________________________

Date: _______________  Time: _______________

Printed Name: ___________________________________________________________________